THE JOURNAL OF SCHOOL HEALTH

Vol. XX No. 7

SEPTEMBER
1950

Gertrude E. Cromwell, R. N.
414 14th St.
Denver 2, Colo.

PUBLISHED BY
THE AMERICAN SCHOOL HEALTH ASSOCIATION

AMERICAN SCHOOL HEALTH ASSOCIATION

Organized 1927

Devoted to the interests and advancement of those engaged in school health activities and the service rendered by them

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THE JOURNAL OF SCHOOL HEALTH

THE AMERICAN SCHOOL HEALTH ASSOCIATION

3335 Main Street, Buffalo 14, N. Y.

Published monthly, except July and August, at Buffalo, N. Y.

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SUBSCRIPTION RATES TO THE JOURNAL

Membership dues, $3.00 including Journal: Subscription $3.00

Single copies 35c, send payment with order

Address all communications to
THE EDITOR, The Journal of School Health
3335 Main Street, Buffalo 14, N. Y.

Copyright, September, 1950, by
The American School Health Association

Entered as second-class matter at the Post Office at Buffalo, N. Y.
October 5, 1937

THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XX SEPTEMBER, 1950 No. 7

AN OPTIMUM SCHOOL HEALTH PROGRAM

C. H. MAXWELL

*The chief of administration of School and College Health Services, U. S. Office of Education, discusses an optimum health program and the factors upon which it depends.**

"What is an optimum school health program?"

"That depends."

When asked to write a description of an optimum school health program, the assignment seemed puzzling because what might be an optimum program in one area of the country, or in one size of school system, or under one set of conditions might not be optimum in another. The optimum school health program must depend upon the availability of resources, that is, resources in personnel and facilities. Both may be dependent to a large measure upon finances.

1. *Basic Optimum Program*

If we assume that the school has available only the services of the classroom teacher, there are certain basic fundamentals which are essential. For that school the basic program might be the optimum available. First of all, a good health program cannot exist in a poor environment. There is no reason why even a one-room school cannot have a happy, healthful, friendly atmosphere.

There should be a minimum of health and safety hazards in the school and its environment. There should be a program of activities for the children which includes a planned program of meeting the physical activity needs of growing children of varying physical capacities. There should be a health teaching program which provides the child with a basic number of health facts, a desirable group of health habits, and a wholesome attitude toward himself and his fellow men.

Even the one-room country school, through its teacher, should provide a certain amount of health services, the most important of which is the teacher's daily observation of the school child for any obvious changes from his usual condition. She would then refer any suspected deviations through the parents to more competent technical resources. The teacher should screen the children at the beginning of the school term for any serious suspected deformities

*Now with the Washington Office of the American Medical Association.

or handicaps and refer them through the parents for medical diagnosis and care. She should have a program of directing all children through the parents to the dentist for examination at least once, preferably twice, annually. The dental supervision of school children is particularly urgent, since dental defects are the most common defects in school children and, in some areas, are found in as high as 95 per cent of all school children.

In her own screening procedures she should weigh the children or have them weigh one another (when they are old enough) and report to the parents any children, not obviously overweight, who do not gain over a period of 3 months. The frequency of weighing children is not universally agreed upon. As a part of the teaching procedure in school the children may weigh one another once a month. If the teacher must do this less frequently, at least once in 3 months should be insisted upon, as this simple procedure may find a number of children whose health habits and physical condition need further supervision.

The teacher also should screen the children for possible handicaps in vision and hearing. In testing for hearing, a simple watch tick or whisper test may be helpful. On the other hand, the teacher's observation of the children in school may find hearing defects not disclosed by a whisper test or watch tick or even at times an audiometer. Signs ordinarily looked for are:

1. Discharge from ears
2. Earache
3. Failure to hear questions
4. Picking at the ears
5. Turning the head to hear
6. Talking in a monotone
7. Inattention
8. Anxious expression
9. Excessive noisiness of child

The teacher can also screen the children for defective vision with a simple Snellen Chart or other vision-testing apparatus. In addition, the teacher should observe the children for symptoms of eye strain. Some of the signs of eye defects which the teacher should be alert for are:

1. Sties or crusted lids
2. Inflamed eyes
3. Crossed eyes
4. Repeated headaches

5. Squinting, frowning, or scowling
6. Protruding eyes
7. Watery eyes
8. Rubbing of eyes
9. Excessive blinking
10. Twitching of the lids
11. Holding head to one side.

In the basic program there should be a school health committee consisting of those in the school having most to do with the health of the individual child (in the one-room school it will necessarily include the classroom teacher), and representatives of the parents and community agencies. If there is a health officer or public health nurse serving the area, they will ordinarily be members of the committee. This will assist in interpreting the school health program to the community and obtain the guidance and support of the community for the program in the school.

2. *Optimum Program with Minimum Health Service Personnel*

In addition to the basic program described above, additional procedures should be carried out when there is available a small amount of services of health service personnel. Each school should have available a medical adviser named by the school trustees or board of education. He may be paid or unpaid, and should serve as a consultant to the teacher or principal in charge of the school in matters involving the health service program, and, at times, in the general health program. He may serve also as a resource person in the health teaching program.

Often, in sparsely settled areas, he will be the most readily available physician in the area, and might be the individual whom the school would call in case of emergency.

The public health nurse, the visiting nurse, or the school nurse in the community will serve also as an adviser and consultant to the teacher in school. The nurse will learn from the teacher much about the child's problems and behavior in school and will furnish the teacher at times information concerning the home conditions of the child.

With the minimum amount of nursing time, the nurse will attempt to perform no particular service in the school to individual pupils, but may help the teacher in demonstrating and planning mass vision and hearing testing and in other screening technics which the classroom teacher would carry out. The nurse might assist in the follow up, but may be able only to advise the teacher as to how the cases should be followed up.

The health committee or health council in this type of program should have as members, among others, the nurse and physician who are the consultants to the school, and the public health nurse and health officer, if there are such in the community. The function of the committee, of course, would be broadened as the specialized personnel becomes more plentiful. The coordination of the program with the health and education program will have increasing importance.

Each school should have, in addition to a health committee, an advisory committee from the local medical and dental society to whom the school can present its problems for guidance and help. This will do much to keep the professional health groups informed concerning the school health program, and help obtain the support and guidance of these groups who should be consulted in planning the programs. Because of the customs and code of ethics which have grown up in these professions, the invitation to participate in a program will necessarily come from the schools to these groups instead of from the professional health groups to the school.

3. *Optimum Program with Small Amount of Health Service Personnel*

If health service personnel is more readily available, the first two programs listed above might be expanded to include at least an entrance medical examination of all school children, with the proper guidance of the teacher in the follow up. The entrance examination is preferably done with the parent present so that the child's habits can be ascertained and the plan for follow up of suspected defects can be properly carried out. The entrance examination preferably should include the examination of the teeth by a dentist or dental hygienist.

The ideal program is one in which the examinations are done by the private dentist and physician, and the result of the examination reported to the school. The parents and pupils are thus taught that medical care and health supervision are their responsibilities, and not that of the community. Where the parents are unable or unwilling to provide these services for their children, other arrangements should be made. These examinations may be provided in or out of school.

If time permits, the nurse may actively assist in the follow-up program by making home calls which she could not do in the minimum program listed above.

4. *Optimum Program with Moderate Amount of Health Service Personnel*

In the areas where a moderate amount of health service personnel is available, the above programs can be expanded to include the routine periodic examination of all the school children and the examination of children referred because of special problems. It is generally agreed that periodic medical and dental examinations of all school children are desirable. There is a difference of opinion about the spacing of these examinations. The consensus is that the most important examination is the entrance examination. Thereafter, examinations may be spaced at intervals depending largely upon the amount of physician time available.

An examination in the third or fourth grade, another in the seventh or eighth grade, and the final one in the tenth or eleventh grade is a frequent method of spacing. Whether the examination is provided in the school or privately will depend upon the financial situation of the families and the success with which the desirability of providing health services privately is taught to pupils and parents.

With a moderate amount of nursing time, the nurse in some cases is given responsibility for annual vision testing, and hearing testing at intervals that are considered desirable. There is a growing program of providing dental hygienists for examining the teeth of school children, cleaning some of them, and applying sodium fluoride as a prophylaxis against dental decay. The dental hygienist is also spending an increasing amount of time in giving individual and group instruction in care of the teeth and gums.

With a moderate amount of medical service, the generally accepted program is to provide special examinations and supervision of the interscholastic athletic squads. Usually there is no need to urge this program upon the schools as the increased risk these children undergo makes boards of education anxious to see that the children are protected as much as it is reasonable to do so. The additional protection which the board of education gets in case of accident, should lawsuit arise, makes the supervision of these squads probably better carried out than many of the other phases of the school health program.

The physician doing the examinations should devote a definite part of his time to discussing the health problems of the child with the parents, who should be present at the examination. An exception is at the high school level where the parents' presence would hamper the examinations and restrict the child's freedom to talk. The physician should make a definite effort to draw out the

child in conversation so that he will get an understanding of the possible speech difficulties the child may have. He should spend a definite part of his scheduled time in individual health counseling at the time of the examination or when the child is referred to him or comes to him with special problems.

The health committee or health council will function much the same as in the first two programs discussed, and can better guide the school because of more adequate personnel.

5. *Optimum Program with a Liberal Amount of Health Service Personnel*

It is the consensus of leaders in pediatrics that the optimum medical supervision of children of school age should include an annual examination of all school children and the examination of those referred for special problems. However, since this may be an expensive procedure in some areas where medical care is not easily provided, this program is not carried out in most of the schools in this country. The death rate of children of school age is lower than that of any other age. Some leaders in the field feel that we should scrutinize carefully the use of funds in providing the examination of children in this most healthful period of their lives.

It must be borne in mind throughout that a medical examination catalogs the child only for the time being and that school personnel—particularly the teacher—should feel free to refer children time and again for suspected illness, physical defects, or for suspected deviations from usual normal health.

Consultants to whom the school may turn for advice and guidance in the various programs are highly desirable. These consultants include an ophthalmologist, an otologist, psychiatrist, orthopedic surgeon, orthodontist, children's dentist, and child guidance personnel. These may be paid by the schools, provided through other community resources, or serve as voluntary consultants. Their guidance is often of the utmost importance.

Health counseling by the school physician would be relatively the same amount as indicated in Program 4.

With a liberal amount of nursing time available the nurses act more and more as health counselors to the children and do increased home visiting. The nurses may do much of the vision and hearing testing and, when in the building, provide first aid care of school emergencies.

However, if the classroom teacher is not involved in hearing and vision testing, she may lose her alertness to symptoms and signs of defective vision and hearing. If the nurse does the vision-

hearing testing, the teacher must be stimulated in other ways to keep alert for signs and symptoms suggestive of defects in vision and hearing.

The school health committee or health council will have a broader base and a wider function in coordination because the program is more extensive.

Summary

The optimum school health program has certain basic requirements. The schools should have a happy, friendly atmosphere and be relatively free from physical and mental hazards. There should be a definite health teaching and guidance program through which the child acquires a basic number of health facts. He should be led to cultivate a desirable group of health habits and a wholesome attitude toward himself and his fellow man. There should be a program of physical activities meeting the needs of the growing child. The teachers should carry out certain basic screening procedures and be constantly on the alert for deviations from the child's usual healthy condition and refer such deviations through the family for further evaluation and possible care.

There should be a health committee for guidance in this program, serving also to keep the community informed and sympathetic.

In addition, when health service personnel is available, the schools should, as a minimum, have a physician and a nurse to serve as advisers. With more adequate personnel, such as nurse, physician, dentist, dental hygienist, audiometer technician, vision testing technician, et cetera, routine and special examinations can be carried out. Consultants in the various specialties in medicine and dentistry may materially improve the program.

It must be borne in mind throughout that a medical examination catalogs the child only for the time being and the school personnel should feel free to refer children time and again for suspected deviations from the child's usual normal health or for suspected illness or physical defects.

It is generally accepted that the program of examinations means little unless there is follow up and guidance for defects or suspected defects found. Furthermore, any school health program that is effective should result in improving the health habits of children, when indicated, or strengthening good habits.

A health program can be optimum for any level of service and facilities available. The selection of activities and procedures will vary, depending upon the amount of services and facilities provided.

A DIRECTIVE FROM HISTORY*

ELEANOR METHENY
University of Southern California
Los Angeles

In some old copies of the Proceedings of the American Association for the Advancement of Physical Education I recently came upon a paper presented by Dudley Allen Sargent at the Chicago meeting in 1893. As I read it, I became excited. It was so vital, so pertinent, as timely as it was timeless, and I immediately wanted to share it with all of our professional generation, who are sometimes confused in these modern days, even as our forefathers were confused in 1893.

The battle of the German and Swedish systems was at its height; the flurry of Delsartism had swept across the country; Roberts' short, simple, easy, pleasing, and beneficial exercises had found favor with many; but no clear-cut American philosophy had yet emerged in crystallized form. Physical education—then, as now—wore many names and appeared in many guises.

Emotions were at fever pitch on that dramatic as well as historic occasion when Sargent rose to speak. Calmly, analytically, and incisively he laid bare the heart of the controversies, noted the contributions made by each of the warring systems, suggested the then-unheard-of concept of the "natural" program, and laid the basis for a distinctively American philosophy of physical education of the individual in terms of his needs as an individual.

Our terminology, our "systems," our issues of today differ from those of 1893, but the logic, the rationale that will dissipate much of our postwar confusion and give meaning to our efforts is the same now as then.

But let Dr. Sargent say it in his own inimitable fashion:

> In reviewing the life of man upon the earth, it must not be forgotten that four-fifths of this period, according to the latest authorities, is shrouded in darkness; in other words, it is prehistoric. But no student of evolution believes that man's early life was spent in simply considering the lilies of the fields as they grew, or in watching other wonders of the firmament.
>
> All the evidence we have of primitive man implies a constant struggle with natural forces, and with wild beasts and savage foes, that must have severely tested his physical strength and endurance. Those that survived this trying ordeal must have been able to run, jump and swim, to climb, push, pull, wrestle and fight, to hurl stones, wield clubs, and to lift and carry their burden through forest and stream, over rocks and cliffs, to their mountain caves. Within historic times, the progress of civilization has always depended upon the overcoming of material obstacles. Force has met force, and the energy and strength required in clearing forest, breaking up ground, laying

*Reprinted by permission from the Journal of the American Association for Health, Physical Education and Recreation, October 1949, page 514.

out roads, and in building up towns and cities with their myriad trades and industries, have given energy and strength to the masses in return for their efforts. The pioneers of a new country are invariably a hardy people, and few suffer for want of physical activity. As the country becomes settled, division of labor sends some to the fields, others to the workshop, others to the office and desk, and so on through all the diverse methods of employment, until we find men scarcely using muscles and faculties enough to keep them in a healthy condition.

These are some of the circumstances and changes of environment which have led to variation from the normal in the past, and will lead to still further variations in the future. Under such a regime, the muscles become atrophied, the vital organism becomes enfeebled, and man enters upon a state of physical deterioration. This is exactly what is taking place today in our great cities, and among a certain portion of the population in rural communities.

The only remedy is more intimate contact with nature, and a return to simpler modes of life, or the universal establishment of artificial methods of physical training.

Since the masses are deprived by circumstances and environments from participating in the best forms of exercise, it would seem that the best substitutes were those forms which furnish the nearest approach to the natural methods, by which man has been brought through the ages to his present state of development. If walking, running, jumping, swimming, climbing, lifting, carrying, pushing, pulling, throwing, etc., have made man what he is physically, why should we not imitate these forms of movement in our artificial systems of exercise? This is what every nation, that has given any attention to this subject, has done for centuries, and all of our athletic games and gymnasium exercises have grown out of man's natural experiences.

If a Japanese, or a Soudanese, or a Sandwich Islander, has well developed deltoids, we know absolutely that either he or some of his immediate ancestry has been in the habit of raising the arms forward, sideways, or backwards. Whether the hands contained a spear, a dumb-bell, an Indian club, or a boxing glove is a matter of little significance, except that a muscle development is quicker where it has resistance to overcome. What is true of the deltoid is true of every muscle in the body. There are a thousand ways and means of developing them, as exemplified by different races and peoples the world over, but when we come down to ultimate movements, we know that they are limited by flexion, extension, abduction, rotation, etc., and that these are common to all classes, and to all systems of physical training.

Where, then, is the essential difference?

1st. In the development of movements and exercises for the development of the flexors, extensors, abductors, etc.

2nd. In the *manner* in which these various exercises are to be executed.

3rd. In the *order* in which they are to be given.

4th. In the *time* to be devoted to each.

5th. In the conditions and circumstances which accompany the exercises.

In the selection of movements and exercises, the choice lies mainly between those without apparatus, such as free movements, calisthenics, dancing steps, walking, running, jumping, tumbling, swimming, etc., and exercises with light portable apparatus, such as dumb-bells, wands, hand rings, balls, bats hoops, Indian clubs, fencing foils, swords, single sticks, vaulting poles, etc. Then there are exercises with what may be termed fixed apparatus, as pulley weights, bars, horses, swings, ropes, ladders, etc.

All systems of physical training have something in their curriculum which corresponds to free exercise, exercises with portable apparatus, and exercises with fixed or heavy apparatus. The reason for this general division of the subject is based upon the fundamental conditions underlying the development of the body.

One of the principal forces with which mankind is always contending is *gravity*. We are battling with this force from morning until night, yielding to it partially as opportunity offers, to assume a sitting position, and finally yielding to it completely, as we do each night, when we sink to rest in a horizontal position.

But this force not only acts upon the body as a whole throughout the day, but upon each individual part of the body. Thus the head tends to drop forward, the shoulders to round over and droop downward, the back to curve, the chest to become flattened and compressed, the knees to bend, the arch of the foot to break down, etc. This is nature's attempt to seek an equilibrium, and this giving way to gravity is the first evidence of approaching senility, disease, and death. The only way that this downward tendency can be overcome is by constant exertion of muscular force. Thus, if it were not for the efforts of the muscles at the back of the neck, the head would drop forward onto the chest; if it were not for those running up the spine, and on the back of the legs, the body would drop forward on the pelvis. The relative amount of force expended by these muscles is largely dependent upon the weight of the head, trunk and limbs, and upon one's habitual attitude. If any part of the body is thrown out of equilibrium, it severly taxes certain groups of muscles, and calls for an unusual expenditure of force. Hence one of the most important objects that the instructor in physical training has to accomplish, is to give his pupils a proper balance or poise. This implies the training and strengthening of muscles from the sole of the feet to the crown of the head. The best means of attaining this object is by free exercises, calisthenics, Swedish free movements, dancing or balancing steps, etc.

But man has not been able to maintain a footing in the world simply by keeping his poise and standing erect. He has been obliged to wield his weapons of defense, use his tools and implements of labor, and bear his burdens, with his hands, arms, or shoulders, while maintaining his poise and walking about on his feet. This necessity of our nature gives rise to the second grand division of physical exercises, as represented in the use of the portable apparatus, such as dumb-bells, Indian clubs, wands, fencing sticks, etc.

But if the superincumbent weight of the body alone tends to make it yield to gravity, this is more likely to be the case where the body has an additional weight to handle. This is especially observed in the peculiar formation of persons who have been accustomed to carry burdens, however light, for any length of time. The tendency is to droop the shoulders, compress the chest, crook the spine, etc.

It is of the greatest importance, therefore, to have a set of exercises that tend to open up the chest by increasing all its diameters. This is admirably done by the use of the parallel bars, hanging rings, stall bars, ladders, booms, and other pieces of heavy or fixed apparatus. The pulley weights and developing appliances afford an excellent means of acting upon the body in any direction, and in this respect they surpass all other apparatus.

The *manner* in which free movements and exercises with and on the apparatus are performed, is a matter of considerable importance. If groups of exercises are selected simply because they are easy, or because they look pretty, or are short, safe, and pleasing, or afford an endless variety, the chances are that a great deal of work will be done that is aimless and ineffective. If, on the other hand, the exercises are selected with a view to their physiological effect, and all of the groups are made up with the intention of accomplishing some important purpose, much better results will follow in a much shorter time.

This seems to me to be the radical difference between the French and Swedish schools. I do not think, however, that it is always necessary or advisable to keep the physiological aim of the exercise constantly before the pupil. Groups of exercises may be arranged which are both pleasing and interesting, and none the less effective from a physiological point of view. It seems to me that the combination of these two extremes, which is effected by the Germans, has much to recommend it.

The aims in view and the conditions and circumstances under which the exercises are carried out, in my opinion, mark the greatest difference in the several systems. In this respect fashion often holds sway, and we are all made to feel the influence of fads in physical training, as well as in other branches of education.

If society demands that woman shall be up in graceful attitudinizing, or that her belles shall have backs as straight as boards, and a carriage equally stiff to accompany them, there will be plenty of teachers who will make these

specialties their stock in trade, and endeavor to give their patrons what they want and are willing to pay for. The absurdity to which these society gymnastics can be carried may easily be imagined when such common-place performances as how to breathe, and how to sigh, or how to sit, and how to rise make up the curriculum of many so-called teachers of physical culture.

Others aim to give grace, suppleness, health, strength, endurance, erectness of figure, obedience to commands, etc. This leads me to say here, as I have often said elsewhere, that in all exercises the qualities at first demanded are the qualities at length acquired. If you wish to give grace, you must give graceful exercises; if skill and dexterity, those that require these qualities; if coolness, courage, and presence of mind, exercises that bring these faculties into play. So in regard to quickness, strength, precision of movement, power of coordinating muscular sense, the art of balancing, and a great many other physico-mental qualities. All may be acquired to a considerable extent by the practice of appropriate exercises.

Now, whether the great variety of exercises necessary to give this broad training is essential to the curriculum of an ordinary school or college, is a matter of judgment and perhaps a matter of taste, depending largely upon what one's views are as to the meaning of the term "physical education."

Certainly few will deny that those who are preparing to teach physical exercises should be as thoroughly grounded as possible in a wide range of subjects. Our normal schools of physical training should be as liberal in this respect as nrmal schools for other branches of training.

Years ago, when I thought I had a system, I was only teaching mechanical drills, and I had yet to learn that the thing for an instructor to acquire was the art of developing power, and of increasing human faculty. This cannot be accomplished by simply teaching set drills or by elaborating stereotyped day's orders. The first lesson in the art of power is to learn to get all of one's muscles under complete control of the will, then to acquire mastery over oneself in a new element, under new conditions, or on a new piece of apparatus. Learning to swim, skate, sail a boat, box, row, wrestle, ride a horse or a bicycle, climb a rope, circle a bar, swing on the rings, jump over an obstacle, and a hundred more things familiar to you all, are processes in physical education.

But in my own opinion, the fundamental basis of every system of physical training should be a knowledge of the condition of the individual, which can only be acquired through systematic measurements and careful observations of persons of different races, ages, sexes, and circumstances in life.

In order to meet the responsibilities growing out of the knowledge, the teacher must be able to analyze every kind of exercise, to know what muscles and faculties it develops, to know its dangers and its weak points, where it should be supplemented by other exercises, and where it is complete in itself. In a word, the teacher should know enough about all exercises to use them for what they are worth without fear or prejudice.

It is in just this respect that it seems to me we can all be mutually helpful to each other.

Today, in 1949, we are a confused profession, even as our forbears were confused in 1893. Old trees die and new trees grow, but the forest remains the same. The trees are so many, so green, and so varied that we contemplate each one in turn and lose sight of the forest as a total entity. We suffer from an embarrassment of riches of objectives, outcomes, programs, and activities, each worth while in its own right. We cannot do justice to all of them, and in attempting to do so we spread ourselves so thin that we accomplish nothing.

Our problem is to make a decision among many services, all of them valuable. The basis for that decision was simple and

obvious to Dr. Sargent in 1893. It still holds good in 1949. First choose the *result* you wish to accomplish, *then* choose the activities, the techniques, the materials, and the methods which will best accomplish that result. We need to bend our professional energies to clarifying our ultimate goal, our reason for existence in the pattern of total education. When we have clearly defined our fundamental and ultimate objectives, then our decisions concerning the relative merits of the many specifics which confuse us will be made with ease and assurance.

* * * * *

School Nurses, Connecticut,—The following account of the development of the newly formed School Nurses Association of Connecticut may be of interest to our readers.

A group of sixty-five school nurses met on Thursday, May 11, at Sunset Ridge School in East Hartford to adopt a constitution and elect the following officers:

Mrs. Ella Bray, Supervisor of School Nurses, Torrington, Connecticut, President.

Miss Stella Kornacki, School Nurse, Plymouth, Connecticut, Vice President.

Miss Marjorie Shallue, School Nurse, Fairfield, Connecticut, Secretary-Treasurer.

Active membership in the association is open to school nurses in Connecticut regularly employed by boards of education. Associate membership is open to any school health personnel not eligible for active membership. All educational programs sponsored by the association will be open to anyone interested in school health.

Unquestionable stimulation was brought to these Connecticut School Nurses through the advice and consultation given their Temporary Advisory Committee by Miss Elsa Schneider, Specialist in Health Instruction and Physical Education for the U. S. Office of Education and the encouragement offered by Miss Emily Brown, President of the School Nurses Association of New Jersey. Miss Brown gave unselfishly of her time to come to meet with the school nurses of Connecticut so that they might benefit from the experiences encountered by their New Jersey sisters when the School Nurses Association of New Jersey was organized some two years ago.

The Connecticut State Department of Education, Bureau of School and Community Services offered these Connecticut school nurses moral support and advice through the services of Mrs. Helen T. Watson, Consultant in School Nursing.

Sincerely yours,

(Mrs.) HELEN T. WATSON, Consultant in School Nursing.

OKLAHOMA SCHOOL OF THE AIR THROWS THE SPOTLIGHT ON HEALTH*

Oklahoma is probably most famous for Will Rogers, oil wells on the State Capitol grounds, Indians, and as one of the last remaining dry states in the Union. It is not famous for the program of health education carried on in the schools. Central leadership from the State Department of Education in health education is relatively new, though State Superintendent Oliver Hodge has moved toward the development of such a program. At the moment there are about 2700 school districts in the state. Rural education, with a few notable exceptions in the form of community schools, lacks many of the attractive features we have come to consider essential to a good modern education. This is the background which should be known in any attempt to understand why the University of Oklahoma has been interested in exploring avenues by which it might enrich the programs of our rural school and encourage the teachers and children together to attempt to improve conditions by joining community groups in programs of action for health improvement.

The author of this report is not an expert in radio education —but when the University of Oklahoma radio station WNAD began to plan for an expansion of its School of the Air as an aid to rural schools, he requested time for a health series. As a result of this request, he has, almost since that moment, had the hot breath of next week's program requirements breathing down his neck. But students, teachers and dozens of community agencies have helped to keep the program going for three successive semesters with about seventeen consecutive weekly programs a semester.

It was decided from the very first that we would try to secure advice and participation from as many persons and organizations as possible. It was also agreed that the children would be consulted whenever feasible and used in the broadcasts. The first use of children came in the selection of a title for the series. Several hundred children reported their preferences by means of a check list of about ten or a dozen of the most catchy titles a class of teachers could suggest. "Spotlight on Health" was selected as the children's choice from this preferential ballot.

The first use of adults and representatives of community groups in planning the series of programs, aside from students in health methods classes, came when a group of specialists in

*Abstract; Teachers' Manual: by Health Education Classes, College of Education, University of Oklahoma.

education and various health and related fields was called together to review the plans which the class in Health Education had prepared. Students in the health class, many of whom were rural teachers, had agreed upon a tentative schedule of broadcasts relating to major health problems of children and the homes and communities from which they came. For each proposed broadcast there was an accompanying lesson plan which included:

A statement of the *objectives* of the lesson.

Suggested activities to be carried on by the teacher *before the broadcast.*

A brief and general statement of the broadcast program and suggested *after the broadcast* activities.

In addition, the lesson plan listed appropriate materials in the form of available periodical literature, free or inexpensive publications, helpful visual aids such as posters, films and film strips.

Each lesson plan contained a great deal more than a teacher could possibly use in connection with a single broadcast. It was recognized that some topics—such as Safe Water (The State Health Department reports that more than three-fourths of our rural farm wells are unsafe, or unsafe when tested bacteriologically, according to standard methods of water analysis) might require a full semester of study and effort by children and teachers in order to secure action towards improvement.

The lesson plan on Safe Water contained references to one health text, four magazine articles, three moving pictures, one sound slide film, two posters, and five free or inexpensive governmental publications.

As a class project after the broadcast activity, the teacher's manual lesson on water suggested that schools enlist the help of their county health department sanitarian or county (agricultural) agent to test the wells in the school district. In 1948-49 improvement of home water supplies was one of the two major projects which county agents throughout Oklahoma were promoting. In Cleveland County, the seat of the University, more than a dozen schools carried out this project with either the county agent or sanitarian who worked closely together. Requests for water inspection were received from 400 farm homes. Water supplies were sampled bacteriologically where the well met sanitary standards for construction. Any well which was structurally unsafe was not sampled for bacteriological testing for obvious reasons.

Besides a lesson on home water supplies, lessons were developed on sewage disposal, garbage and waste disposal, insect and

rodent control, school sanitation, nutrition (three lessons) and safety. An effort was made to suggest ways in which children could originate, assist and promote worthwhile school-community projects in these areas.

The consultants who advised us on the development of our plan represented the: State Department of Education, the State Department of Health, State Teacher Education Institutions, County Superintendents, the State P.T.A. Office, the University Medical School, Home Demonstrator, County Agent, and numerous other voluntary and official agencies.

In order to attempt an evaluation of the program a group of teachers was solicited, and those who volunteered to serve on a "listening committee" were asked to report on every third broadcast.

During the first semester of this effort there were about 4,000 children in (??) classrooms scattered in (??) schools in (??) counties in Oklahoma who were reported to be listening to the program. Now, after two semesters of effort, the program is reaching about 15,600 children in grades 5 through 8. In addition, an unknown number are listening to the programs outside of the University of Oklahoma broadcasting range for the State Health Department is distributing recordings of this series to several other radio stations throughout Oklahoma, where some sponsoring group is interested in promoting the program.

Our efforts have been largely of the amateur variety. Radio is a very transitory and ephemeral medium and probably cannot compare in stimulus-to-action value with sound film or TV, but it is relatively inexpensive and *can* bring a message of interest or a personality to thousands of children.

During the second semester of our efforts it was decided that in addition to a new topic each week, we would throughout the season plug three objectives—better breakfasts; safe water; safe milk on the farm. Every third session we planned to come back to one of these major topics for a two or three-minute comment, more or less in the manner of a radio commercial. We might have some football hero tell why he ate breakfast and what he ate.

Despite our interest in evaluation, we have not yet, because of limited resources, carried on any worthwhile studies of results achieved. Many teachers claim that their children enjoy the programs, but we realize that the kids are shut in the classroom and listen willy-nilly in some cases. We hope to make their fifteen minutes an exciting and interesting adventure, but I am sure we

fail dismally at times. We know that we will not, by radio alone, be able to make a contribution of any consequence to the children unless the teacher is interested in having her pupils learn and do something worthwhile for better health in connection with the program. We can do little more in fifteen minutes once per week than to provide the teacher who takes her responsibility for the health of children seriously with another small weapon to aid in her endless battle against that omnipresent triumvirate ignorance, apathy, and superstition.

Radio is here to stay and TV may soon be available in our schools. Are we going to use these devices in part at least for the benefit of our children, or shall electronics via the airwaves continue to be primarily the tools for selling more cigarettes, liquor, cosmetics, candy, and creating bigger and more insistent demands for things?

As a result of his experiences, one thing only seems clear to this novice. A radio audience of thousands will try out educational programs, but unless the programs meet the felt needs of teachers and interests the children, they won't come back for long.

We need more professional talent than most of our University broadcasting stations can afford if we are to match the opportunities we have. In Oklahoma we cannot lightly use fifteen minutes of the time of 20,000 pupils — which amounts to a total of 5,000 pupil hours of listening. We have an obligation to find out more than we currently know about what happens as a result of radio listening by our enrollees. But we hope, perhaps mistakenly, that we can add something worthwhile to the teacher's efforts to promote better breakfasts (for example) if we ask Bud Wilkinson —the genial University of Oklahoma football "coach of the year" —to give his ideas about breakfasts to a boy who interviewed him for our listening children. It is that *plus* something we hope to add by radio in our Oklahoma School of the Air.*

*Statement by Laurence T. Rogers, Professor of Health Education.

THE MENTALLY ILL CHILD

By EDWARD PODOLSKY, M.D.

Mental illness in children, though not as common as among adults, does nevertheless exist. The child who is mentally sick, exhibits certain characteristics with which every parent should be acquainted. When the illness is discovered in its earliest stages a great deal can be done to bring about a cure.

There are six points to be kept in mind which characterize the mentally ill child. These are:

1. A generalized withdrawal of interests. The child is not interested in his surroundings. He lives within himself, completely separated from people and places. He has lost contact with his environment, with his surroundings and everyone about him.

2. His ways of thinking, feeling and acting are not the same as those of other children. They are quite unusual, queer and bizarre.

3. He has disturbances in thought manifested by not being able to talk without suddenly stopping in the middle of a sentence, leaving out important words, incoherence and sometimes remaining mute.

4. He has not the usual emotional responses. His emotions may be stunted or he may not have any emotional responses whatsoever.

5. His way of feeling is rigid. His facial expressions become fixed and rigid and he lacks emotional depth.

6. His behavior undergoes a change, either becoming overactive, or underactive, or his behavior may become fixed and bizarre.

What should the parent be on the look-out for as the earliest signs of mental illness? First is what the psychiatrists call early dissociative phenomena as seen in the disturbed integration of language design and language function. In simple words, this means the tendency of a child of two to five years of age to use words not as a means of expressing thoughts and feelings, but as mere phonetic signs devoid of any meaning. The very young, preschool child enjoys using words for the sake of words. This represents a play with sounds which is an entirely normal manifestation. In this play, it is very obvious that the child gets considerable gratification out of such activity. The parents sometimes become a little tired of this play and refer to it as silly or nonsense talk. However, when this is found in an older child in whom playfulness is absent, and who has a serious, mask-like expression when uttering these silly or nonsense words, there may be an underlying

mental illness. In some children, the unwillingness to learn to speak may be an indication of complete lack of interest in the world about them, and a sign of mental illness.

The second important factor in detecting mental illness in children is the child's lack of interest in people, in his environment and in the activities of other children. Such a child is prone to have imaginary companions, or to talk about themselves in the third person. They do not mingle with other children and find no interest in their play. They have no playmates.

The third factor is that of compulsions. A young child may well repeat an activity which he has found pleasurable without this activity becoming compulsive. The playfulness with which he performs and the enjoyment he gets out of this activity stamp it as normal. This is in contrast to the compulsive type of behavior as seen in a child whose interest in play is very slight. He speaks very little with others. He does a thing over and over again, such as counting a series of cards, but there is no emotional coloring to the act; he derives no pleasure from doing it; he counts because of some inner compelling force.

Another form of compulsion is that of compulsive possessiveness. It is true that young children usually go through a period of collecting many strange objects. In contrast to this early childhood habit of collecting, compulsive possessiveness is characterized by an intense drive for storing objects of no concrete value or significance. Such a child is apt to look compulsively at automobile licenses, retain the numbers, or make lists of them, an obviously useless acquisition, if one considers the range of a young child's interests. He may collect a variety of bits of strings or rags at an age when a normal child has long passed this collecting stage.

Temper tantrums may be a sign of mental illness. When temper tantrums are observed with some degree of severity and persist in the five to seven-year period and beyond, they are not normal. They reveal the inability of the child to take frustrations, which a normal child is able to take.

Another symptom of mental illness in children is marked aggressiveness when the child is first in contact with other children. It is usually noted at the time when the child begins to talk —approximately at two years of age—and not knowing what to do with other children, strikes them. When such a child is prevented from expressing his aggression toward other children he may turn his aggression toward himself, tearing his clothes, biting himself, striking himself, etc.

On the other hand, the child, who, after the usual period of social adaptation, persists in not playing with other children, is fearful, and clings to adults, deserves careful attention.

Each of the above factors in itself may have no significance, but when they all occur together they are a pretty good sign that the child is mentally sick, and that something should be done about it.

What can be done about it? Quite a great deal. First is the prompt recognition of the abnormal signs and symptoms, and second is getting expert psychiatric advice. There are many child mental hygiene clinics devoted to the care and treatment of such cases.

The people who come in close contact with young children, parents, teachers, judges, and others should become aware of the signs of abnormal behavior and should be able to recognize them early.

What are the solutions? From a practical point of view at the present time, the available solutions are psychotherapy, manipulation of the environment or removal from the environment. Psychotherapy is of immense value in many cases of mentally ill children. An expert is required for this phase of the work. The manipulation of the environment is frequently unattainable because of the non-cooperation of the parents who are quite often neurotic themselves. The earlier the problem is treated, the better are the chances for success.

Good mental health depends on attention to a variety of influences which may be described under ten basic principles:

1. Eugenics and the right of the child to be well-born. Being well-born depends on good prenatal, obstetrical and pediatric care.

2. The physical welfare of the child in all stages of his development. Debilitating and distressing physical handicaps too often prevent children from enjoying mental health at its best.

3. A satisfying home life for the developing child, not only from the economic point of view, but from the environmental as provided by the parents.

4. Good habit formation. Here the parent-child, teacher-child, and inter-child relationships are important in building habits which will strengthen the personality. Good sex instruction is very important.

5. The development of good foundations for the mental superstructure. These foundations are four different aspects of security to be achieved by training, education, and environment; security

in one's self; in one's affectionate relationships; in one's fellows; and finally, in the outer world which provides a satisfying philosophy of living.

6. The understanding and avoiding of certain unhealthy mental mechanisms. Two of these, in particular, are important—projection and rationalization. These are dependent upon a desire to be always right in order to avoid feelings of guilt and discomfort.

7. The understanding and practicing of a desirable mental mechanism, sublimation: the refining of our crude, primitive unethical desires and aggressive drives into ethical, socially valuable goals and achievements.

8. The development of constructive escapes. Everyone needs such escapes, but they should be constructive, adding something to the personality as well as giving temporary surcease from care.

9. The regulation of one's emotions, which determine to a large extent the way one thinks, believes and acts, and even influences the state of one's physical health. Children can be emotionally inoculated by learning how to react to the minor difficulties of childhood so that they will not collapse emotionally when faced with the more serious stresses of adulthood.

10. The improvement of environment. While difficulties are needed to develop mental strength, these environmental difficulties should not be excessive.

* * * * *

Use of Hot Packs in Poliomyelitis,—To the Editor:—At the monthly meeting of the Lawrence County Medical Society the question arose as to the effect of the hot pack treatment for poliomyelitis on the anterior horn cell. Does the application of hot packs to affected areas in the early stages of the disease actually have some effect on the anterior horn cell, or does the hot pack treatment simply have its effect in the way of preventing contracture?—*Dale E. Scholz, M.D., Lawrenceville, Ill.*

ANSWER—There is no conclusive proof that hot pack treatment has any ultimate effect either on the anterior horn cells or on the development of contractures. Any statement regarding the effect of this treatment on the ultimate outcome in poliomyelitis must at present be based on clinical impressions rather than on adequately controlled tests. Most clinicians believe that "hot packs" ameliorate pain and are helpful in establishing and maintaining normal muscle length and thus assist to minimize contractures (Methods of Clinical Study and Evaluation on Therapeutic Agents in Poliomyelitis, Council on Pharmacy and Chemistry, J. A. M. A. 140:534, June 11, 1949).

Journal of the American Medical Association, February 25, 1950, p. 610.

COOPERATIVE ACTIVITY FOR COMMUNITY HEALTH: THE WATERBURY PROGRAM

ROBERT E. SCHNEIDER, M.S.P.H., Ed.D.

Cooperative activity for community health improvement has become increasingly prominent during the last quarter century. Today such groups as the American Medical Association and the American Public Health Association endorse and contribute to this developing interest, while in many communities, departments of public health and education, non-official health groups and interested lay citizens are working together for the improvement and development of public health programs.

In Waterbury, Connecticut, a city of 107,000 population, the cooperative activity for community health has reflected in the main, the serious interest of the Health Section of the Community Council of Waterbury. It is described here because of the effectiveness with which this group has met the generally accepted criteria for successful health council operation.

The objectives of the Health Section are:

1. To interpret the public health program to the community in order to have it adequately used and supported.
2. To assist in maintaining high standards of service.
3. To assist in developing a cooperative program with all of the public health agencies of the community.

The duties of the Section are:

1. To be familiar with what are the accepted standards in the field of public health.
2. To have a thorough understanding of the health needs and resources in the community and to initiate studies as required.
3. To interpret the program of the organization.
4. To speak in behalf of the health budget before the appropriating body, general assembly and such committees as may be necessary.

The Health Section operates through a Steering Committee which appoints committees to function in the several specialized areas of health need as these are reflected in the community. Functioning at this time, in addition to the Nominating, By-Laws Revision and Publicity Committees, are the following committees:

Dental Health Committee
Committee on the Hard of Hearing
Committee on Infant Mortality
Committee on Referrals

Waterbury Alcoholic Clinic Committee
Committee on School Health Policies

Among others, the work of the Committee on School Health Policies has been outstanding. This group, endorsing the School Health Policies Report of the National Committee on School Health Policies, studied, over a one year period, with representatives of the Department of Education, the then existing school health program in the light of community health needs and offered its support to the Department of Education in the development of an extended program. As a result of this effort, the Department of Education operates today in close liaison with the Waterbury School Health Council, with the object of coordinating all aspects of the school health program, of developing the total program in a manner consistent with the recognized health needs of the community, and of coordinating the school health program with the health education efforts of the several official and non-official health groups which operate in the community.

The supervisor of the school health program is active in the Health Section activity and in close touch with its membership. He enjoys the advice and assistance of the Waterbury School Health Council which operates on a city-wide basis as an advisory group, and of many members of the health professions and agencies as well. This community interest, cooperation and assistance in the school health program illustrates, in fact, the very type of community support for its activities which is so desirable and helpful to departments of public education generally.

The Waterbury School Health Council is an outgrowth of the activity of the Committee on School Health Policies. Exercising an advisory function only, it illustrates a cooperative enterprise which reflects the common interest in community health of the health and education departments, the local medical and dental professions and the lay public, in the development of an outstanding school health program.

Today the Health Section is both a listening post and a sounding board for all who would work together for the improvement of the public health in Waterbury. **Abstracted by H. F. Kilander.**

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EDITORIAL

Dudley Allen Sargent:

Pioneer, student, gymnast, teacher, organizer, leader, Doctor of Medicine and man.

To him, physical educators in this country owe a great debt which they can never repay.

Born in Belfast, Maine, at the mid-point of the nineteenth century and living practically all his life within sight of salt water, he had the experiences of a small town adventurous child and boy, even to running across the broken ice in a salt bay.

A sailor before the mast—for one voyage—Belfast to New York city; a self-taught gymnast, so expert that for a time he was employed as a high trapeze performer in a circus; the first instructor in the new gymnasium at Bowdoin College—at the same time student and his own janitor; later, instructor in the gymnasium at Yale where he finally acquired credits enough to win an M.D. degree; and then Director of the new Heminway Gymnasium at Harvard where he gradually built up what for the era was probably the most complete apparatus equipment in America including many pulley devices which he himself devised. These had the basic elements present in nearly all the physical medicine pulley weight and friction types of apparatus in use today.

He also was the practical inventor and great exponent of "strength tests", which, to his everlasting credit, he recognized as such, and not as tests of general physical fitness. He used his

strength tests as diagnostic tools to discover weak muscle groups which needed a prescription of special exercises for their upbuilding.

As we read his sedate and calm presentation of the situation as he saw it, we are deeply impressed by the innate "horse sense" of the man. This is particularly noteworthy in a period of development of physical education when most of the so-called "leaders" were not teaching physical education at all, but a "system."

Of these "systems" R. Tait MacKenzie, in his editor's Preface to the first edition—1923—of Leonard's, "A Guide to the History of Physical Education,, says, "The shore of physical education is strewn with the wrecks of systems and movements, many of them good in themselves, but left to drift when the personal support and enthusiasm of the founder was removed from the helm."

We continue to have "systems" vehemently supported by their advocates. These have ranged all the way from Reilly's "New Rational Athletics," and Pearl and Brown's "Health by Stunts" through "Natural Dancing" which of course ceases to be natural as soon as instruction enters; to more recent fads and fancies.

The history of education itself is strewn with fads—or are they advertising media—which are advocated as revolutionary and all important, but soon are swamped by later oncoming waves of vociferous publicity. The better of them tend to remain incorporated in the general body of educational procedure while most disappear as froth from the shore.

We would not be "the last to lay the old aside," but we do caution against particularities. It takes many things other than one swallow to make a summer, and it takes an enormous variety of activities and attitudes to bring about real "physical education."

Teachers poorly trained in activities must inevitably become faddists. They can teach only the things that they themselves know and can do.—*C.H.K.*

PROGRAM ANNUAL MEETING
AMERICAN SCHOOL HEALTH ASSOCIATION
ST. LOUIS, MISSOURI, OCT. 30 - NOV. 4, 1950

Monday, October 30, 1950 — 9:30 A.M.

FIRST GENERAL SESSION—

Presiding, WILLIAM AYLING, M.D.

Theme: *"The Nurse in the School Health Program"*

1. *Administrator's Point of View*
   C. MORLEY SELLERY, M.D.
   Director of Health
   Services, Los Angeles City Schools, Calif.
2. *Nurse in a Specialized Program*
   MRS. HENRIETTA SCHWARZLER, P.H.N.
   Staff Nurse, Denver Public Schools, Colorado
3. *Nurse in a Generalized Program*
   MISS KAY DIERKES, P.H.N.
   Staff Nurse, St. Louis County Health Dept., Missouri
4. *Nurse in a Jointly Administered Program*
   MISS PATRICIA HILLIARD, P.H.N.
   Staff Nurse in the Joint Program Hammond, Indiana

SECOND GENERAL SESSION—

Monday, October 30, 1950 — 2:30 P.M.

Presiding, GERTRUDE CROMWELL, P.H.N

Theme: *"School Health Problems"*

1. *Common Skin Conditions Met in School*—color slides
   A. R. WOODBURNE, *M.D., Specialist in Dermatology*
   Denver, Colorado
2. *Examination and Evaluation of Athletes*
   THOMAS E. SHAFFER
   Ohio State University, Columbus, Ohio
3. *Family Life Education*
   MISS HELEN MANLEY
   Director of Health, Physical Education and Safety
   University City Public Schools, Missouri

Monday, October 30, 1950 — 8:30 P.M.

Presiding: J. A. MYERS, M.D.

Theme: *"Tuberculosis Control Programs"*

1. *Tuberculosis Among Members of School Personnel*
   D. O. N. LINDBERG, M.D., *Medical Director*
   Utah State Sanatorium, Ogden, Utah

2. *Importance of and Accomplishments in Tuberculosis Control Among School Children*
S. A. SLATER, M.D., Medical Director
Southwestern Minnesota Sanatorium, Worthington, Minn.

3. *The Part of Local Practicing Physicians and Tuberculosis Control in Schools*
L. L. COLLINS, M.D., Medical Director
Madison County Sanatorium, Edwardsville, Ill.

4. *Tuberculosis Control and Teaching Tuberculosis in Schools*
DAN MORSE, M.D., Medical Director
Peoria Municipal Tuberculosis Sanitarium

— and —

R. H. RUNDE, M.D., Medical Director
Peoria County Chest Clinic, Peoria, Ill.

5. *Certification of Schools with Reference to Tuberculosis Work in Progress*
L. S. JORDAN, M.D., Medical Director
Riverside Sanatorium

— and —

KATHLEEN JORDAN, M.D., Staff Physician
Minnesota Public Health Association, Riverside Sanatorium
Granite Falls, Minn.

6. *Can Tuberculosis Be Eradicated from School Children*
EDWIN R. LEVINE, M.D.
Michael Reese Hospital, Chicago, Ill.

Cordially,

FOURTH GENERAL SESSION—DINNER MEETING—

Wednesday, November 1, 1950, 6:30 P.M.—

Presiding: WILLIAM E. AYLING, M.D., *President*

Presentation of the William A. Howe Award
Responses by Recipients
Dinner Speaker

PAUL B. KINNEY, M.D.

ABSTRACTS AND NOTES

Reading Disabilities in Children,—There is a group of children, estimated by Monroe to amount to about 12 per cent of all children in the United States, who fail to learn to read as well as the average of their class. These children have normal or better than normal intelligence and normal social and vocabulary development. Most of these children have normal vision. Occasionally one encounters dyslexia* associated with left handedness, particularly when attempts had been made to convert left handedness to right handedness. The disability manifests itself in a variety of ways, such as confusion of one consonant with another, as b for d, p for q and t for f, or a reversal of syllables, words or entire sentences, as in mirror writing, or complete failure to recognize a word. Criticism by the teacher and parents makes the child lose confidence in his ability to do school work and leads to the development of various emotional problems, with psychologic blocks which further aggravate the condition.

The etiology of the development dyslexia is not clearly understood. It is doubtful that there is in these children any underlying organic lesion, such as the agenesis of the dominant angular gyrus. The absence of any other evidence of intracranial damage speaks against this hypothesis. Emotional factors such as fear, anxiety, rivalry, jealousy, hostility for the parent or the teacher and a feeling of inferiority undoubtedly play an important role in creating these difficulties. It is significant that many of the complexes associated with the reading disability disappear with improvement in reading.

Crisp[1] and Rychener[2] believe with Orton that the new method of teaching reading, the so-called "flash" method, is an important contributory in the creation of these disabilities. The "flash" method employs whole words on cards with pictorial representation to develop pure visual associations. The method was expended into a phrase and later into a sentence method. The child on entering school immediately learns to read whole sentences. The analysis of the sentence into individual words and the analysis of individual words into phonic sounds are taught secondarily, when the child already has an extensive reading vocabulary based on visual memory rather than on synthesis of words. Berner and

*Dyslexia—difficulty in reading.

1. Crisp, W. H.: The Psychology of the Poor Reader, Am. J. Ophth. 33:235 (February) 1950.

2. Rychener, R. O. and Robinson, J.: Reading Disabilities and the Ophthalmologist, Tr. Am. Acad. Ophth. 53:107 (November-December) 1948.

Berner[3] point out that, while this method produces rapid and intelligent readers, it tests to the limit the child's power of attention and concentration. These authors feel that certain minor difficulties such as low hypermetropia and deficient fusion, which were of minor importance under the older methods of teaching, have now become significant.

Crisp and Rychener and Orton believe that a small percentage of children need phonetic training. According to Orton among children who have been taught by the "flash" method there were three times as many cases of reading difficulties as among those who had been taught by the phonetic method. Crisp feels that emphasis on speed rather than on accuracy in the development of a new skill, such as reading, must increase the subconscious sense of defeat and conflict in a child's mind, to be followed by failure in further efforts.

The important elements in the treatment of these disabilities are their earliest recognition and sympathetic handling of the problem. Training in phonetics, remedial reading and the employment of every means to restore the child's confidence in his ability to read make for favorable prognosis. The advantages of the older, the phonetic method, as contrasted with the new, the "flash" method, particularly as related to developmental dyslexia, is a problem to be solved by the cooperation of the ophthalmologist and the pedagog.

The complexity of the problem of dyslexia, involving endocrine inbalances, dietetic errors, occasionally ocular difficulties and psychologic problems, such as the emotional reaction of the child toward the teacher and the parent, makes it evident that supplementary tutoring by a parent or teacher will seldom accomplish the goal. Dyslexia in all its phases is best treated in special institutions staffed by specialists in various reading disabilities. The Reading Difficulty Center of Columbus, Ohio, the Memphis Orthoptic Center of the Dsylexia Memorial Institute in Chicago[4] are some of the institutions engaged in this work.

* * * * *

TB Deaths Among Children Decrease,—Children in this country have shown an extraordinary reduction in mortality from tu-

3. Berner, G. E. and Berner, D. E.: Reading Difficulties in Children, Arch. Ophth. 20:829 (November) 1938.

4. Schmieding, A.: How Dyslexia Memorial Institute Helps the Non-Reader, Exceptional Children 13:36 (November) 1946. Macmillan, D. P.: Dyslexia (Reading Difficulty), Library J. 71:890 (June 15) 1946, from The Journal of the American Medical Association. Editorial April 15, 1950, p. 1218.

berculosis during the past two decades. Among youngsters between one and 14 years of age, the death rate dropped more than 80 per cent—from 20.4 per 100,000 in 1930 to a low of 3.7 in 1949.

Progress in reducing tuberculosis among children is due, in large measure, to the decreasing frequency of contact with adults who have active disease and who constitute the chief source of tuberculosis infection in children, according to a report of the Metropolitan Life.

The decline in tuberculosis among children has also resulted from improvement in environmental conditions. The better care and feeding of children, the prevention of debilitating diseases, high standards of community and personal hygiene, and the reduction in substandard housing have all played a part.

At present, the problem of tuberculosis in childhood is greatest in the pre-school years. Mortality rates at these ages are appreciably higher than in the 5 to 14 year groups. At the pre-school ages, and to a lesser degree at 5 to 9, tuberculosis of the meninges and central nervous system is of greater importance than respiratory or the other forms of the disease.

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BCG in Prevention of Tuberculosis,—According to Levine, the use of BCG in the prophylaxis of tuberculosis is still controversial, in spite of the present wave of enthusiasm over the employment of the method. The loss of virulence of the bovine tubercle organism in BCG is complete and permanent, and the use of the vaccine in human beings is entirely safe. Many favorable reports have been published abroad on the efficacy of BCG but the studies, with few exceptions, have been poorly controlled. Controlled studies on tuberculosis mortality have been reported from New York City and Chicago and from Indian reservations in the United States. Although the results were favorable, suggesting that a certain degree of immunity against the development of primary tuberculosis is conferred, the degree of this immunity as well as the duration of the immunity has not been determined. The use of common antituberculous measures, such as case detection, separation of contacts, hospitalization, mass roentgen studies, tuberculin testing of cows and pasteurization of milk, has been so successful in the United States that the need for a prophylactic agent such as BCG is less acute than in countries lacking adequate antituberculosis facilities. Before the use of BCG can be accepted as a general public health measure, considerable knowledge concerning the actual degree of immunity conferred by BCG, the duration of immunity following vaccination, the optimum method of administering the vaccine, the effectiveness of the vaccine under varying

degrees of exposure, in different racial groups with various degrees of resistance, when given to different age groups and when prepared with different culture mediums is still necessary. The BCG vaccine can in no way be offered as a substitute for other antituberculosis methods so successfully used in the United States. At best, it may be offered as a supplement to already existing control measures in this country.

Journal of the American Medical Association, January 21, 1950, p. 208. Abstracted from "Diseases of the Chest", September 1949, p. 288.

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Basketball at a Girls' School,—To the Editor:—A new gymnasium teacher in a girls' school believes that girls from 11 to 14 years of age should not play basketball because stretching is bad for them. All the girls are upset at the decision, and I would like to know whether there is any medical reason for this opinion.—*Gordon M. Bruce, M. D., New York.*

ANSWER—There is no reason why a basketball program developed especially for girls, employing girls' rules conducted apart from the boys' program, and coached and officiated by competently prepared women should not provide a wholesome sports activity for girls. The physical condition of prospective players should be appraised by medical examination before participation, and medical judgment should determine fitness to return to play after serious illness or injury. The most desirable program is one emphasizing intramural competition (games between teams from within the school) with an occasional sport-day involving neighboring schools in which social objectives are stressed. The varsitl pattern of championships and strenuous schedules is not recommended for girls.

Modification of the game and its rules, including shortening of playing periods, allowing for frequent substitutions, and extending the length of "time-out" and the number permitted per quarter, are some of the measures that will act as safeguards in adapting the game to the 11 to 14 age group. During the menstrual period exercise should depend on individual forms of competitive sport during the first day or two of the period for most girls, with restrictions indicated by personal experience prevailing later. A few girls may require rest during the entire period.

A good physical education program offers a wide variety of worth while experiences to meet the varying needs of pupils. Enthusiasm for basketball or any of the so-called major sports should not be allowed to center attention on one game to the exclusion from the program of other desirable forms of activity.

Journal of the American Medical Association. February 25, 1950 p. 607.

California,—At the annual meeting of the California Division of the American School Health Association held at Sacramento, April 1, 1950, the following officers were elected for the year 1950-1951.

California Division
April 1, 1950

Officers for 1950-1951

President—C. Morley Sellery, M.D., Director of Health Services, Los Angeles City Schools.

Vice-President—Mrs. Gjertrud Smith, M.S., Vice Principal, Belmont High School, Los Angeles, California.

President Elect—Lydia Smiley, P.H.N., Redlands Public Schools, Redlands, California.

Treasurer—Mrs. Frances Miller, B.S., Health Coordinator, John C. Fremont High School, Los Angeles, California.

Secretary—Mrs. Georgia Reed, P.H.N., Los Angeles City Schools.

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The New York State Association of School Physicians, at its annual meeting at Lake Placid, N. Y., in June, elected the following officers for the year 1950-1951.

Officers

Edward L. Schwabe, M.D., President, Brocton, N. Y.; Stephen A. Mahady, M.D., Vice-President, 13 Elizabeth Street, Utica, N. Y.; William F. Mitchell, M.D., Secretary-Treasurer, 501 Irving Ave., Syracuse 10, N. Y.

Executive Committee

Lillian DeArmit, M.D., Albany, N. Y.; Harry C. Beatty, M.D., Kenmore, N. Y.;Adfur E. Maines, M.D., Buffalo, N. Y.; Charles H. Keene, M.D., Buffalo, N. Y.; Edith Gardner Mead, M.D., Poughkeepsie, N. Y.

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REVIEWS

"Preventive and Corrective Physical Education",—George T. Stafford, Ed.D., A. S. Barnes and Co., New York 1950; pp. 312, price $3.75.

This is a revised edition of the text which was first issued in 1928.

The chapters include—New Hope for the Handicapped; Physical Medicine; Preventive and Corrective Physical Education; Body Mechanics; The Treatment of Faulty Body Mechanics; The Feet; Heart Disturbances; Malnutrition; and Poliomyelitis and Cerebral Palsy.

The material is simply and clearly stated, well illustrated with line drawings and pictures of conditions and procedures. It is an excellent text for teachers and students of physical education.

There is great need of more and of more precise and more scientific instruction and practice in this field. This need is being emphasized by the increasing number of poliomyelitis cases and the growing appreciation that great improvement is possible for the cerebral palsy cases.

An excellent text for the student and practitioner in the enormous field of Physical Medicine.—*C.H.K.*

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"Recent Advances in Social Medicine",—Alan Carruth Stevenson, M.D., The Blakiston Co., Philadelphia, 1950, pp. 241, price $4.00.

This text, by English authors and written largely from the English point of view, covers a group of topics rarely presented in a single American text: Measurement of Growth of Children; Infant Mortality; the Health of Children in Communal Day Nurseries; the Unmarried Mother and Her Child; Problem Families; School Medical Inspection; Some Applications of Statistical Methods; and (a) Psychosomatic Illness and Social Medicine, (b) The Adolescent in Industry, (c) Pulbreems, a Method of Classification for the Armed Services.

The first and seventh chapters on—Measurement of Growth, and on School Medical Inspection should particularly interest readers of the Journal of School Health.—*C.H.K.*

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"A Guide to Teaching Effective Living",—A course in Health and Safety Education for Senior High Schools: Bulletin 4-B, State Dept. Education, Florida, pp. 341—1950.

This Bulletin contains a large amount of valuable information of a factual sort on such topics as Cosmetics, Alcohol, Drugs, Mental Health, Social and Mental Development during the Adolescent Period, Problems and Experiences in Community Health and Safety.

This guide offers much material which should be valuable to the teachers in Florida Schools.—*C.H.K.*

"Textbook of Healthful Living",—Harold S. Diehl, M.D. McGraw Hill Book Co., Inc., Fourth Edition, pp. 776, price $4.00.

This is the revision of a text frequently used in college classes on hygiene and health education. It contains new chapters on Community Health; Communicable Disease Control; Insects, Animals and Diseases; Sanitation and Health; Health in School and on the Job; Government and Health; Voluntary Health Services; and Future Planning for Health.

There is also an appendix of 186 pages devoted mostly to the diagnosis and control of a number of communicable diseases, most of them rare in the United States.—*C.H.K.*

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Home Nursing Textbook, American Red Cross,—Blakeston Co.. Philadelphia, 1950, pp. 235, Cloth $1.00, Paper $.60.

This is the sixth revision of the official Red Cross textbook on home nursing—since the publication of "Elementary Hygiene and Care of the Sick" in 1913.

The text contains a great deal of worthwhile information concerning the early symptoms of the more common diseases, household emergencies, first and more detailed instruction about usual routine procedure that should be used in the household care of the sick.—*C.H.K.*

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"Health Education in Elementary Schools",—Helen Leslie Coops, Ph.D., A. S. Barnes and Co., New York, 1950, pp. 279, price $3.50.

The contents of this text aim at providing the teachers with information regarding activities, materials and methods for use in classroom instruction in health education.

After dealing with the meaning of health in modern living, it takes up curriculum development and organization and contents (very briefly) of the School health program, then discusses activities and projects, and, lastly, presents sixteen teaching units of various grade levels.

The major weakness is that at times it launches into areas that are not health education in the best meaning of the term; but are factors outside health education which in the minds of most public health officers and health organizations, and of school health workers, outside the physical education group—is a term confined to health training and instruction.—*C.H.K.*

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Speech Problems of Children,—Edited by Wendell Johnson, Ph.D., Prepared for National Society for Crippled Children and Adults by the American Speech and Hearing Association. Pub-

lished by Grune and Stratton, New York, N. Y., 1950. 261 pp. $3.75.

As a help to parents, physicians, teachers and others concerned with school children affected by speech problems, several leading speech correction workers and pathologists have collaborated in writing "Speech Problems of Children," a guide to care and correction.

Written in language easily understandable to the layman, the book contains chapters on the major speech disorders, with each chapter written by a different authority.

The book is edited by Wendell Johnson, Ph.D., director of the speech clinic at State University of Iowa. Chapters cover a broad survey of the problem, speech in the home and speech in the school, children who "don't talk plain," children who are slow in learning to speak, children with cleft lip and cleft palate, children with cerebral palsy, children with voice disorders, children with hesitant speech, children of foreign tongues and children with impaired hearing.—*Abstracted by C.H.K.*

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SANITATION: Bathing Beaches, Contamination of Water at Beaches. Journ. A.M.A. Feb. 25, 1950, p. 607.

TUBERCULOSIS: Increase of Tuberculosis, Apparent or Real. Editorial. Journ. A.M.A. June 10, 1950, p. 556.

VISION: Basic Requirements in School Lighting. *Miles A. Tinker,* Journ. Am. Med. Assn., May 27, 1950, p. 362.

WHITE HOUSE CONFERENCE: Midcentury White House Conference on Children and Youth. History, Plans, etc. Journ. A.M.A. June 17, 1950, p. 625.

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MEETINGS

American School Health Association and the American Public Health Association at St. Louis, Mo., October 29-November 3, 1950. Headquarters at the Hotel Jefferson. American Association for Health, Physical Education and Recreation, at Detroit, Michigan, April 14-20, 1951.

The Annual Convention of the National Society for Crippled Children and Adults will be held October 26, 27 and 28, 1950, at the Stevens Hotel, Chicago.